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**HOW TO FILE A CLAIM**

Please follow the instructions listed below to avoid unnecessary delays in processing your claim. This form must be fully completed for each disability claim. If the claim form is not fully completed, the processing of the claim may be delayed.

**Employer:** 1) Complete and sign Part I answering all questions;

2) Attach job description; and

3) Attach proof of earnings as defined by applicable policy (example: payroll records, W-2, K1, 1099, etc.)

**Insured:** 1) Complete and sign Part II answering all questions; and

2) Complete and sign the AUTHORIZATION FOR USE IN OBTAINING INFORMATION form, and

3) Have the attending physician complete and sign the ATTENDING PHYSICIAN STATEMENT.

Fax to: 860-272-1137

Or Mail to: Plan Administration, LTD

580 Hazard Avenue

Enfield, CT 06082

# RELIANCE STANDARD

Life Insurance Company

## Short-Term Disability Benefits Initial Statement of Claim

<b>PART I FOR EMPLOYER TO COMPLETE</b>					
Name of Insured (Last, First, Middle Initial)		Date of Birth		Social Security No.	Policy No.
Job Title	Insurance Class	Hire Date	Date Enrollment Card Signed	Effective Date of Insurance	
Date Laid Off (If Applicable)	Date Retired (If Applicable)	Weekly Earnings	Date Last Worked	Date Returned to Work	
Is Employee receiving sick leave benefits from present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date Began	Dated Ended	Reason For Stopping Work	
Is disability work related? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," Explain			Brief Description of Duties		
Percentage of premium paid by: Claimant % Employer %		If claimant pays any portion of the premium, please indicate whether the claimant's portion of the premium is paid with: <input type="checkbox"/> Pre-tax dollars <input type="checkbox"/> Post-tax dollars			
Is there any reason why FICA taxes should not be withheld from claimant's benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain:					
Employer Name & Address			Employer's Telephone Number Ext.		
Authorized Signature	Date	Fax Number		Email Address	
<b>PART II FOR INSURED TO COMPLETE</b>					
Home Address (Street, City, State, Zip)			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Dominant Hand: <input type="checkbox"/> Right <input type="checkbox"/> Left	
Is this Claim Based on an accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Did injury occur at work? If "Yes," for whom were you working? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date you were first unable to work because of this disability		
Date of Accident (if any)	Time <input type="checkbox"/> AM <input type="checkbox"/> PM	How and where did accident happen?			
Name and Address of Attending Physician				Date you returned to work	
Are you now receiving Unemployment Compensation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you now receiving or eligible to receive as a result of this disability: Social Security <input type="checkbox"/> Yes <input type="checkbox"/> No Worker's Compensation <input type="checkbox"/> Yes <input type="checkbox"/> No		State Disability <input type="checkbox"/> Yes <input type="checkbox"/> No No Fault Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes" give name and address of insurer, amount of income, date benefits began and ended.		
<p><b>We are required to withhold federal income tax from any benefit payments upon your request. If benefits are taxable by your state, we will also withhold state income tax upon your request. We must also send a report to your employer at the end of each calendar year showing your name, social security number, any benefits paid and any taxes withheld. If you would like us to withhold any taxes, please indicate the dollar amount to be withheld each week:</b></p> <p>Federal Tax to be Withheld _____ (\$20.00 Minimum per week, whole dollars only)            State Tax to be Withheld _____ (\$ 2.00 Minimum per week, whole dollars only)</p>					
<p><b>Any person who knowingly and with intent to injure Reliance Standard Life Insurance Company files a statement of claim or submits any information in conjunction with a claim containing fraudulent, false, misleading, incomplete or deceptive information commits a fraudulent insurance act, which is a crime. These actions will result in the denial of the claim, and are subject to prosecution under state and/or federal law. Reliance Standard Life Insurance Company will pursue any and all appropriate legal remedies arising from such fraudulent insurance acts.</b></p>					
Insured's Signature		Date	Telephone Number ( )	E-Mail Address	

**AUTHORIZATION FOR USE IN OBTAINING INFORMATION**

NAME OF INSURED: \_\_\_\_\_  
INSURED'S SSN: \_\_\_\_\_  
POLICYHOLDER: \_\_\_\_\_

To all physicians and other health care professionals, hospitals, other health care institutions, insurers, medical, hospital and prepaid health plans, pharmacies, employers, group policyholders, contract holders, governmental agencies (including but not limited to the Social Security Administration), private and/or public benefit plan administrators, and/or attorney representatives, including but not limited to covered entities and business associates under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the accompanying regulations:

You are authorized to provide Reliance Standard Life Insurance Company and/or its authorized administrators with information concerning medical care, advice, and/or treatment provided to me, the above named Insured, and/or any employment, salary and/or benefit-related information concerning me, the above named Insured. I understand that the disclosure of information may include disclosure of protected health information under HIPAA and the accompanying regulations, information regarding treatment for mental illness, the human immunodeficiency virus (HIV) and/or the use of drugs and alcohol. I also understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be subject to protection under HIPAA and the accompanying regulations. A statement of Reliance Standard Life Insurance Company's privacy policy is available at [www.rsli.com](http://www.rsli.com) or upon request.

I understand that any such information will be used for the purpose of evaluating my claim for benefits. Upon request, I understand that I am entitled to receive a copy of this Authorization. This Authorization is valid from the date signed for the duration of the claim, and may be revoked by me at any time upon written request to the address above. A reproduction of this Authorization shall be considered as valid as the original.

\_\_\_\_\_  
Date  
**(If the Insured is unable to sign, an authorized person may sign.)**

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Person's Signature

Description of Authorized Person's authority to sign on behalf of Insured:  
\_\_\_\_\_

**PART III ATTENDING PHYSICIAN'S STATEMENT (PLEASE ANSWER ALL QUESTIONS AND SIGN)**

Patients Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Diagnosis and Concurrent Conditions (including ICD-9 codes) \_\_\_\_\_

Surgical or Obstetrical Procedure \_\_\_\_\_

Current Medications \_\_\_\_\_

Frequency of Treatment  Weekly  Other  
 Monthly

Is condition due to injury or sickness arising from patient's employment?  Yes  No  
 Has patient ever had same or similar symptoms?  Yes  No  
 If Yes, when \_\_\_\_\_

Date symptoms first appeared or accident happened \_\_\_\_\_  
 Date patient first consulted you for this condition \_\_\_\_\_  
 Is patient still under your care for this condition?  Yes  No

If condition is due to pregnancy, give LMP and expected date of delivery. LMP \_\_\_\_\_  
 Expected Date of delivery \_\_\_\_\_  
 If patient hospitalized, give name of hospital Admission Date \_\_\_\_\_  
 Discharge Date \_\_\_\_\_

Is patient able to perform his/her job?  Yes  No  
 Date patient was continuously unable to work From \_\_\_\_\_ To \_\_\_\_\_

Estimate date patient should be able to return to work. \_\_\_\_\_  
 Patient will be partially disabled From: \_\_\_\_\_ To: \_\_\_\_\_

**MENTAL CONDITION**

Is the patient competent to endorse checks and direct the use of the proceeds thereof?  Yes  No

**COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO CARDIAC CONDITION**

**CARDIAC**

Functional Capacity (American Heart Ass'n)  Class 1 (no limitation)  Class 2 (slight limitation)  
 Class 3 (marked limitation)  Class 4 (complete limitation)

Blood Pressure and Dates \_\_\_\_\_

**COMPLETE THIS SECTION ONLY IF DISABILITY IS DUE TO VISUAL IMPAIRMENT**

**VISUAL IMPAIRMENT**

What was vision at last observation?		Snellen Notation			
		O.D.	O.S.	Month	Day
With Glasses					20
Without Glasses					20

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Physician's Name, Address, ZIP (Please Print or Type) \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Specialty \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_ Degree \_\_\_\_\_ Physician's Tax ID No. \_\_\_\_\_

**IMPORTANT: PLEASE ATTACH ALL MEDICAL RECORDS FROM THREE (3) MONTHS PRIOR TO DATE OF DISABILITY TO PRESENT.**